ROANOKE COUNTY

PLANNING
5204 Bernard Drive, Second Floor, P.O. Box 29800
Roanoke, Virginia 24018-0798
TEL: (540) 772-2068
FAX: (540) 776-7155

Philip Thompson,
DIRECTOR OF PLANNING

PLANNING
TRANSPORTATION
ZONING

CORTRAN VERIFICATION REQUIREMENTS

This Transportation Program is for Roanoke County Residents Only

As part of the application process, please provide a copy of the following documents for verification purposes. Applications will not be processed until documentation is received. Please allow five business days for completion once application and all documentation is received.

1. **Documentation of Age, *one* of the following:**

☐ Driver's license
☐ Passport
☐ Birth certificate
☐ Other government issued ID that includes date of birth

2. **Documentation of Roanoke County Address, which can include but is not limited to *one* of the following:**

☐ Utility bill, *not more than two months old*, issued to the applicant (examples include gas, electric, sewer, water, cable or phone bill).
☐ Receipt for personal property taxes or real estate taxes paid within the last year
☐ Current automobile, home, or life insurance bill
☐ Voter registration card
☐ Driver's license, learner's permit or DMV-issued photo ID
☐ Deed, mortgage, monthly mortgage statement, or rental/ lease agreement

This is a ride share program with a limited number of rides available Monday through Friday. Your requested pick up time may not be available. A form of payment must be set up prior to scheduling your ride. No payment is accepted by the driver.

CORTRAN Application

CORTRAN
P.O. Box 29800
Roanoke, Virginia 24018

PHONE: (540) 776-7271
FAX: (540) 283-6750
EMAIL: CORTRAN@RoanokeCountyVA.gov

Si necesita una aplicación en español, por favor visite, https:www.roanokecountyva.gov/CORTRAN

Check one: New Application ____ Recertification ____
Please check ALL that apply regarding your eligibility to utilize the CORTRAN service:
Disability _____ 65 years or older _____

SECTION 1. CLIENT INFORMATION

1. First Name: _____Last Name: _____ Gender: _____
   Address:_____
   City: _____State: _____ Zip Code: _____
   Date of Birth: _____ Phone Number:_____ Veteran? _____
   Alternate Phone:_____Email: _____
   Preferred Notification Method (check one): Text___ Phone Call___ Mobile App___

2. Complete this section ***ONLY if Current Address is Temporary*** *(nursing home, rehab facility, or hospital)*
   Facility Name: _____
   Address: _____
   City: _____State: _____ Zip Code: _____
   Phone Number: _____

3. Emergency Contact
   Name: _____ Phone Number: _____
   Relationship to Client: _____

   Optional demographics: White ___ Black or African American ___ Hispanic / Latino or Spanish___
   Asian ___ American Indian / Alaskan Native ___ Hawaiian or other Pacific Islander___
   Middle Eastern or North African ___ Other_____

CORTRAN ADMIN ONLY: Funding Source_____ Age_____ District_____
Eligible From_____ To_____ Staff Initials _____

SECTION 2: NEEDS ASSESSMENT

1. Do you have a disability that limits you from providing your own transportation?
   Yes___ No___ If yes, please explain limitations and accommodations needed:
   _____

2. Is this disability temporary? Yes ___ No ___ If yes, how long do you expect to be limited from providing transportation? _____

3. Do you use any of the following mobility aids or specialized equipment?

☐ Long White Cane (visually impaired)	☐ Oversized Wheelchair	☐ Larger Mobility Device
☐ Prosthesis	☐ Portable Oxygen	☐ Power Scooter
☐ Crutches	☐ Powered Wheelchair	☐ Service Animal
☐ Walker	☐ Manual Wheelchair	☐ Personal Care Attendant
☐ Cane	☐ Leg Braces	

4. Please list the name of the Personal Care Attendant: _____

   **Only one personal care attendant may ride with you, no other guest is permitted on the vehicle

5. In order for the CORTRAN service to transport you safely and comfortably, please include your approximate weight along with any ***special equipment*** or instructions to transport you below.

   Weight: _____ Special instructions: _____

   _____

If someone other than the applicant completed this application, please complete the section below.

Name: _____ Facility: _____

Primary Phone: _____Relationship to Applicant: _____

***** Please allow up to five business days to process the application. Applications will not be processed without current documentation being provided.**

Title VI Public Notice

Roanoke County is committed to ensuring that no person is excluded from participation in, or denied the benefits of its transportation services on the basis of race, color or national origin, as protected by Title VI of the Civil Rights Act of 1964. If you feel you are being denied participation in or being denied benefits of the transportation services provided by Roanoke County's, CORTRAN Program, or otherwise being discriminated against because of your race, color, national origin, gender, age, or disability, you may contact: Kristie Jordan, 5204 Bernard Drive, Roanoke, Virginia 24018, Phone (540) 283-8109, or email kjordan@roanokecountyva.gov.

SECTION 3: CERTIFICATION AND POLICY AGREEMENT

I certify that the information contained in this application is correct and truthful to the best of my knowledge. I understand that the purpose of this application is to determine whether I am eligible to use the transportation services provided by CORTRAN.

By signing, I agree to report any change in my circumstances regarding eligibility for CORTRAN services to CORTRAN as soon as I am aware of such change. Further, I understand that documentation of all eligibility factors may be required to determine my eligibility or for auditing purposes and that knowingly giving false statements may result in disqualification from participating in the CORTRAN program.

I acknowledge that I understand that CORTRAN enforces the following policies:

- No Show Policy and Failed Payment Policy.
- Service may be approved for up to two years, after that period, clients must recertify. Individuals meeting eligibility based on a temporary disability must recertify every 6 months. A new application must be completed to recertify. It is the responsibility of the client to initiate the recertification process.
- There is no charge for ONE personal care attendant to accompany a CORTRAN client. An individual who is certified as a CORTRAN client is NOT permitted to act as a personal care attendant for another CORTRAN client. CORTRAN riders may not take "guests" on trips.
- Service is provided curb to curb and at no time will a driver enter a building to provide assistance. A driver will provide limited assistance during boarding and exiting the CORTRAN vehicles.
- Please provide documentation to verify age, Roanoke County residency, and have a medical professional complete the Certificate of Disability *if under* the age of 65.
- ***This is a ride share program with a limited number of rides available Monday through Friday. Your requested pick-up time may not be available.***
- ***A form of payment must be set up to schedule your ride. No payment is accepted by the driver. CORTRAN account funds are non-transferable and non-refundable.***
- By signing, I acknowledge and agree that information which is collected through my application for the use of CORTRAN, including demographic information and information about the rides that I take, will be accessible to both the County of Roanoke and Virginia Regional Transit, and will be used to help administer and provide the service.

_____ _____

Applicant or Family Member/Responsible Party Signature **Date**

CORTRAN

County of Roanoke Transportation

Certification of Disability Form

The purpose of this form is to provide written, independent verification that the applicant named below has a disability according to the definition in the Americans with Disabilities Act. This form is to be completed by a medical provider who is familiar with the applicant's disability.

The applicant has applied for transportation services under the County of Roanoke Transportation program, which is being administered by Virginia Regional Transit. If you have any questions about the form, please call (540)776-7271. **Completed forms may be emailed to CORTRAN@RoanokeCountyVA.gov**

Applicant Name: _____

Address: _____

City/State: _____ Zip Code: _____

_____ _____

Applicant or Family Member/Responsible Party Signature **Date**

Definition of Disability

Eligibility for this program is based on disability as defined by the Americans with Disabilities Act (ADA). According to the ADA, "Disability means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment." "...major life activities mean functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and work."

This section to be completed by the medical provider providing verification of eligibility information for anyone under the age of 65.

Is the applicant's disability permanent, lasting longer than 12 months? ____ Yes ____ No

If no, how long is it expected to last? _____

What is the nature of the applicant's disability?

_____ Mobility Disability (See question at right)
_____ Vision Disability
_____ Hearing Disability
_____ Cognitive Disability
_____ Other, specify: _____

Please check all mobility aids that apply.

_____ Manual wheelchair
_____ Power wheelchair
_____ Motorized Scooter
_____ Guide/Service Dog
_____ Requires Personal Attendant
_____ Crutches
_____ Cane
_____ Walker
_____ White Cane

Name of Medical Professional:

_____

Agency/Organization: _____

Address: _____ Phone: _____

_____ _____

Medical Provider Signature **Date**